

IN THE COURT OF APPEALS OF TENNESSEE
AT NASHVILLE
June 23, 2009 Session

**JOHN MARK WATKINS, SURVIVING SPOUSE OF
AMY ROSE WATKINS, DECEASED**
v.
AFFILIATED INTERNISTS, P.C., AND TRAVIS K. PARDUE, M.D.

**An Appeal from the Circuit Court for Davidson County
No. 05C2787 Barbara N. Haynes, Judge**

No. M2008-01205-COA-R3-CV - Filed December 29, 2009

This is a medical malpractice wrongful death action. The plaintiff's decedent underwent surgery and developed an infection after the surgery. The decedent visited the defendant medical clinic, the office of the defendant primary care physician, to treat the pain from the infection. The defendant physician was the supervising physician at the clinic. The decedent was seen by a physician assistant at the clinic, but not by the defendant physician. The physician assistant prescribed the decedent nausea medicine and enough Demerol to take four pills a day for three weeks. The physician assistant did not schedule a follow-up visit. After about two weeks, the decedent called the defendant clinic complaining of nausea and vomiting. The decedent was told to go to the emergency room if she felt dehydrated; she did not go to the emergency room. That same day the decedent died as a result of acute combined drug intoxication. The decedent's husband filed this lawsuit against the defendant medical clinic and the defendant physician, alleging medical malpractice and wrongful death. During the pendency of the litigation, the defendant physician was disciplined administratively for failing to comply with medical regulations that required, *inter alia*, that the physician review the physician assistant's prescription of controlled medication to the decedent. The plaintiff then sought to amend the complaint to include a claim of negligence *per se* against the physician based on the regulatory infraction; his motion was denied. After much discovery, the defendants filed a motion for summary judgment, arguing that the expert testimony adduced by the plaintiff was insufficient to establish the standard of care or that the alleged negligence caused the decedent's death. The trial court granted the motion. The plaintiff now appeals. We affirm the trial court's decision in part and reverse in part. We find that the regulation requiring the physician to review the decedent's chart and data within a certain time period constitutes a standard of care, and that the trial court erred in denying part of the plaintiff's motion to amend the complaint to assert a claim of negligence *per se*. We affirm the grant of summary judgment on the remaining claims.

**Tenn. R. App. P. 3 Appeal as of Right; Judgment of the Circuit Court is
Affirmed in Part, Reversed in Part, and Remanded**

HOLLY M. KIRBY, J., delivered the opinion of the Court, in which ALAN E. HIGHERS, P.J., W.S., and DAVID R. FARMER, J., joined.

David Randolph Smith and Richard A. Demonbreun, Nashville, Tennessee, for the appellant, John Mark Watkins.

Dixie Cooper and Brian Cummings, Nashville, Tennessee, for the appellees, Affiliate Internists, P.C., and Travis K. Pardue, M.D.

OPINION

This medical malpractice claim arises out of the tragic death of a young woman. The appeal centers on whether the expert testimony adduced by the plaintiff supports a claim of medical malpractice so as to survive summary judgment, and whether a regulation pertaining to physicians and physician assistants is a standard of care, the violation of which would constitute negligence *per se*.

FACTS¹

The decedent Amy Rose Watkins (“Decedent”) was a 27-year-old mother at the time of her death. Her complicated medical history included obesity, past alcohol abuse, migraines, and seizures of unknown origin. The record contains some indication that the Decedent had bipolar affective disorder, though it is unclear whether she received treatment for it. For several years, the Decedent used a variety of pain and anxiety medications to treat her migraines and other symptoms, which resulted in her having a high tolerance for pain medication. The record indicates that some of the medical professionals who treated her suspected an addiction to narcotics.²

In 2002, the Decedent began to experience lower back, shoulder, and neck pain. To alleviate these problems, in December 2002, the Decedent underwent a bilateral breast reduction operation. She later developed complications arising out of the surgery, including a MRSA (methicillin-resistant *Staphylococcus aureus*) infection, that necessitated continued medical treatment. On February 3, 2003, the Decedent was admitted to the Vanderbilt University Medical Center (“Vanderbilt”) in Nashville, Tennessee, for treatment of her MRSA infection. Two days later, she was released with intravenous antibiotic infusion care, under the supervision of Vanderbilt Home Health Care Services. The Decedent was also prescribed promethazine (Phenergan) for nausea.

¹As this appeal involves a grant of summary judgment, we recite the facts in a light most favorable to the non-movant, Plaintiff Watkins.

²Although the Decedent did not openly admit that she was addicted to narcotics, she attended meetings for individuals with addiction problems.

On February 18, 2003, the Decedent visited the office of her primary care physician, Defendant/Appellee Travis K. Pardue, M.D. (“Dr. Pardue”), and his medical group, Defendant/Appellant Affiliated Internists, P.C. (“Affiliated Internists”), in Hermitage, Tennessee, for further treatment related to the post-surgery complications. The Decedent did not see Dr. Pardue that day,³ but was instead treated by a physician assistant, Natasha L. Worthington, P.A. (“P.A. Worthington”). P.A. Worthington prescribed the Decedent 90 doses of meperadine (“Demerol”) 100 mg., to be taken every six hours (four times daily) as needed for pain. At the time these medications were prescribed, the Decedent was not given any warnings about the risks of taking them or their potential side effects, and no follow-up visits were scheduled to monitor the Decedent’s usage of the medications.

Approximately two weeks later, on the morning of March 5, 2003, the Decedent telephoned P.A. Worthington at Affiliated Internists to report continuing problems with nausea, vomiting, and dehydration. The Decedent’s message was apparently received by someone else in the office, who then left a note for P.A. Worthington. In the meantime, the Decedent telephoned Care Solutions, Inc., the Decedent’s home health agency, and asked pharmacy technician Sabine A. Owen (“Owen”) whether Dr. Pardue’s office had ordered an IV solution for her dehydration. Owen in turn called P.A. Worthington, who told Owen that she would not order IV fluids for the Decedent to infuse into herself, but that if the Decedent felt dehydrated, she needed to go to the hospital emergency room. Owen telephoned the Decedent’s home and transmitted P.A. Worthington’s instructions to either the Decedent or her husband. The Decedent did not go to the emergency room.

Later that day, the Decedent suffered a seizure and cardiac and/or respiratory arrest. She was taken to the Southern Hills Medical Center in Nashville, Tennessee, and was pronounced dead on arrival.

The next day, the Davidson County Medical Examiner, Thomas Deering, M.D. (“Dr. Deering”), performed an autopsy. It revealed that the Decedent died from “acute combined drug intoxication” from the prescription drugs she was taking, Demerol, Phenergan, and Benadryl.

PROCEEDINGS BELOW

Pre-trial Proceedings

On September 16, 2005, the Decedent’s husband, Plaintiff/Appellant John Mark Watkins (“Watkins”)⁴ filed this wrongful death medical malpractice action against Dr. Pardue and Affiliated

³There is some indication in the record that, at the time, Dr. Pardue was dealing with serious personal health issues.

⁴The decedent’s three minor children were included as plaintiffs to the complaint, but they were later dismissed from the action.

Internists (“Defendants”).⁵ Watkins alleged that the Defendants negligently failed to provide reasonable and appropriate care and treatment to the Decedent and thereby caused her death. Specifically, the complaint alleged that the Defendants negligently failed to properly perform an initial assessment of the Decedent; failed to perform periodic assessments of the Decedent; failed to properly document and chart pertinent information; failed to properly and timely monitor the Decedent’s condition; failed to recognize the seriousness of her condition, including the failure to order her to go to the emergency room for care; failed to prevent the Decedent from becoming toxically medicated; prescribed the Decedent a dose of Demerol that was too large in light of her history of migraines and seizure disorders; and failed to warn the Decedent of the potential lethal risks and toxic side effects of the drugs that were prescribed. On October 17, 2005, the Defendants filed an answer to the Plaintiff’s complaint, denying all allegations of negligence.

On November 30, 2006, the Plaintiff filed a notice and list of experts pursuant to Rule 26 of the Tennessee Rules of Civil Procedure (“Rule 26 Notice”). The Rule 26 Notice disclosed, among other things, the names of expert physicians James N. Jirjis, M.D. (“Dr. Jirjis”) and John A. Mulder, M.D. (“Dr. Mulder”), as well as an expert physician assistant, Donald A. Black, P.A. (“P.A. Black”). The Rule 26 Notice also disclosed the names of Mariana Y. Lu, M.D. (“Dr. Lu”), the supervising physician at Southern Hills Medical Center, the facility to which the Decedent was taken shortly after her death, and Dr. Deering, the medical examiner who performed the autopsy. On December 1, December 4, and December 7, 2006, the Plaintiff amended the Rule 26 Notice to provide increasingly detailed descriptions of the testimony to be given by the named experts. The fourth and final amended Rule 26 Notice was filed on January 31, 2007.

On February 6, 2007, the pretrial skirmishing began in earnest. On that date, the Defendants filed a motion for summary judgment on the sole ground that the Plaintiff lacked any competent expert testimony on the issue of causation. The Defendants also asked the trial court to strike the causation testimony of Dr. Lu and Dr. Deering because the Plaintiff had not complied with the requirements of Rule 26 with respect to these experts. Specifically, the Rule 26 Notice stated that they would “render an opinion as to the cause of death,” without stating what their opinions were. This disclosure, they argued, did not establish that the Defendants’ negligence caused the Decedent’s death. In support of their motion for summary judgment, the Defendants submitted the affidavit of pharmacist Glen E. Farr (“Dr. Farr”), who asserted that nothing Dr. Pardue or P.A. Worthington did or failed to do caused or contributed to the Decedent’s death. Dr. Farr testified that the Demerol prescription was reasonable and appropriate for the Decedent, and that, according to the toxicology report that was done in connection with the Decedent’s autopsy, the levels of Demerol and Phenergan in the Decedent’s blood at the time of her death indicated that she had been taking significantly more of the medications than had been prescribed by any treating provider, including P.A. Worthington. Specifically, the toxicology report indicated that, at the time of her death, the Decedent had 760 ng/mL of Demerol, 601 ng/mL of Phenergan, and 242 ng/mL of Benadryl in her system. Dr. Farr stated that, had the Decedent been taking the medications as prescribed, the levels

⁵The original complaint was filed on March 5, 2003, but the 2003 complaint was voluntarily non-suited on May 13, 2005, and refiled on September 16, 2005.

of Demerol should have been approximately 170 ng/mL, and the levels of Phenergan should have been approximately 11 ng/mL. Therefore, Dr. Farr opined, the Decedent's death was caused by a drug overdose and not by any actions of the Defendants. Thus, in the absence of any proof to refute Dr. Farr's affidavit testimony, the Defendants argued, they were entitled to summary judgment.

On February 23, 2007, the Plaintiff moved to amend his Rule 26 Notice to supplement the disclosure as to the expert causation testimony of Dr. Deering. The Plaintiff also sought to file a copy of the "Addendum Autopsy Report," which elaborated on Dr. Deering's initial opinion by explaining that, although the original autopsy report stated that the cause of death was "acute combined drug intoxication," the term "intoxication" can refer to either toxicity or overdose depending on the circumstances. Because the Decedent died suddenly after having a seizure and/or cardiopulmonary arrest, Dr. Deering reasoned, the Decedent's death was not the result of a "narcotic-type overdose," but was more likely an "adverse drug reaction" to the toxic effects of the medication. Dr. Deering concluded that the prescribed "medications may have provided a toxic rather than an overdose effect on the decedent, resulting in a seizure which then lead to cardiac and/or respiratory arrest." Dr. Deering stated that nothing suggested that her death was anything but accidental.

On March 2, 2007, before the trial court ruled on the Plaintiff's proffered amended Rule 26 Notice or the Addendum Autopsy Report by Dr. Deering, the Plaintiff filed a response to the Defendants' motion for summary judgment. In his response, the Plaintiff relied on Dr. Deering's supplemental report and the testimony of Dr. Lu to establish that the Decedent did not die of a drug overdose, but rather from a seizure secondary to acute combined drug intoxication which resulted from the negligent and substandard medical care provided by the Defendants. Because the testimony of Dr. Lu and Dr. Deering supported his theory of causation, the Plaintiff argued, the Defendants' motion to strike should be denied. In further support of his theory regarding causation, the Plaintiff attached a second affidavit by Dr. Mulder, stating his opinion that the elevated levels of the medications in the Decedent's blood were consistent with the dosage prescribed by the Defendants, and thus that the substandard care given by the Defendants caused the Decedent's death. The affidavit also asserted that the failure of the Defendants to have a "written protocol" as required by state law "resulted in substandard care being given, and that as a result the defendants are responsible for the wrongful death of Ms. Watkins." Thus, the Plaintiff argued, the testimony of Dr. Deering, Dr. Lu, and Dr. Mulder, taken together, created a genuine issue of material fact regarding causation sufficient to rebut the affidavit of Dr. Farr and to defeat the Defendants' motion for summary judgment.

The Defendants objected to the Plaintiff's request to further amend his Rule 26 disclosures, arguing that the amendment was untimely and that it failed to comply with Rule 26. They maintained that, in the proposed amended Rule 26 Notice, the disclosure regarding neither Dr. Lu nor Dr. Deering addressed Dr. Farr's assertion that the Decedent took more medication than the dosage prescribed by P.A. Worthington. The Defendants conceded that the Decedent's death may have been accidental, but they asserted that her death nevertheless was caused by taking more medication than the dosage prescribed by P.A. Worthington. The Defendants argued that Dr. Mulder's causation testimony should not be considered because it was not in the Plaintiff's Rule 26

disclosures, and because Dr. Mulder was not qualified to give an expert opinion in either toxicology or pharmacology.

On March 26, 2007, the trial court heard arguments on the Defendants' motion for summary judgment and request to strike expert testimony.⁶ It reserved its ruling on these issues until after Dr. Mulder's deposition was taken.

On May 25, 2007, the Plaintiff filed a cross-motion for summary judgment. The cross-motion noted that regulations promulgated by the Tennessee Board of Medical Examiners required a physician supervising a physician assistant to develop protocols for the physician assistant, and the undisputed fact that Dr. Pardue had developed no such protocols for P.A. Worthington at the time the Decedent was being treated. The Plaintiff asserted that Dr. Pardue's failure to create and maintain a written protocol for P.A. Worthington was negligent *per se* and was the legal cause of the Decedent's death. The motion asserted that the Plaintiff was entitled to summary judgment on this basis.

Thereafter, on July 19, 2007, the Tennessee Board of Medical Examiners entered a consent order in which Dr. Pardue stipulated that he "did not have satisfactory written protocols for supervising . . . physician assistants." Dr. Pardue also stipulated that "[f]rom September 11, 2002 until March 5, 2003, [Dr. Pardue] did not review patient A.W.'s chart in spite of the fact that she had been prescribed or administered controlled drugs on nine different occasions." In addition to requiring written protocols, the regulations require a physician supervising a physician assistant to "make a personal review of the historical, physical, and therapeutic data gathered by the physician assistant" on a patient for whom a "controlled drug has been prescribed." The physician's review must take place "[w]ithin ten (10) business days" after the physician assistant's examination of the patient. The Board found that Dr. Pardue violated Rules 0880-2-.18(5) and (7) of the TENN. COMP. R. & REGS., promulgated pursuant to Tennessee Code Annotated § 63-6-101, *et seq.* As discipline for violating these regulations, the Board placed Dr. Pardue's Tennessee medical license on probation for five years and required him to pay civil penalties totaling \$9,000.

Soon after that, on July 30, 2007, the Plaintiff filed a motion to amend his complaint to assert that Dr. Pardue was negligent in failing to comply with the above-noted regulations, and that this negligence was the proximate cause of the Decedent's death. In support of his motion, the Plaintiff filed a certified copy of the disciplinary consent order of the Tennessee State Department of Health Board of Medical Examiners. The motion to amend was later amended to include a claim of negligence *per se* based on the violation of these regulations.

In response to the Plaintiff's motion for summary judgment, the Defendants argued that the regulations were merely administrative requirements and did not establish a standard of care. They noted that, even assuming that their conduct constituted negligence *per se*, the Plaintiff was still not relieved of his burden to show that the alleged negligence was the proximate cause of the Decedent's

⁶ A transcript of that hearing is not included in the record on appeal.

death. Because the Plaintiff could not establish that the Defendants' conduct caused the Decedent's death, the Defendants maintained, both the Plaintiff's motion for summary judgment and his motion to amend should be denied.

On August 24, 2007, the trial court heard oral argument on the parties' cross-motions for summary judgment. The trial court denied the Plaintiff's motion for summary judgment. It also denied the Plaintiff's motion to amend his complaint. In a written order, the trial court stated, "Under Tennessee law, negligence *per se* claims cannot be maintained when the statutes in question do not establish a standard of care," and found that "the regulations and statute cited in the Plaintiff's Amended Motion to Amend Complaint do not establish a standard of care, and such amendment would therefore be futile . . ." The Defendants' motion for summary judgment was denied as well.⁷ The trial was set for September 17, 2007.

Prior to the scheduled trial date, on September 14, 2007, the trial court heard oral arguments on the parties' numerous motions *in limine*. The Defendants' Motion in Limine #13 was a motion to exclude the testimony of Dr. Jirjis. The trial court ruled that Dr. Jirjis could not testify as to the standard of care for physician assistants nor as to the standard of care for a physician supervising physician assistants "based upon his own admissions that he is not an expert in these areas." The Defendants' Motion in Limine #19 sought to exclude the standard of care testimony of Dr. Mulder under the locality rule, Tennessee Code Annotated § 29-26-115. At the hearing, counsel for the Defendants agreed to wait until trial to further pursue Motion in Limine #19 to allow Dr. Mulder the opportunity to testify at trial and establish a foundation for his competency to testify as an expert on the relevant standards of care. Therefore, the trial court reserved its ruling on the admissibility of Dr. Mulder's testimony until the morning of trial.

Mistrial

The jury trial commenced as scheduled on September 17, 2007.⁸ The first witness called by the Plaintiff was Dr. Mulder. Dr. Mulder obtained his medical license in Michigan in 1982 and became licensed to practice medicine in Tennessee in 2000. Prior to moving to Tennessee, Dr. Mulder lived in Muskegon, Michigan, and had a general family medical practice there for about seventeen years. Dr. Mulder described Muskegon as "not a very big town," with a population of about 55,000. In his Muskegon practice, Dr. Mulder employed and supervised physician assistants for approximately seven or eight years. In 2000, Dr. Mulder moved to Nashville, Tennessee, to work for a hospice organization administering palliative care and pain management. While working for the Tennessee hospice organization, Dr. Mulder interviewed physician assistants and nurse practitioners for employment. Ultimately, he said, he decided to hire nurse practitioners rather than physician assistants, because he felt that nurse practitioners could better serve the needs of the

⁷The appellate record does not include an order denying the Defendants' motion for summary judgment, but the denial is apparent from the subsequent proceedings.

⁸The first two and one-half days consisted of jury selection, further arguments regarding motions in limine, and other pretrial matters.

organization. In the course of the hiring process, however, Dr. Mulder had discussions with Tennessee physicians about the management and supervision of physician assistants in Nashville, and he also reviewed the Tennessee regulations governing the employment of physician assistants. He opined that, “from a regulatory perspective, there really wasn’t much difference that I could tell between Tennessee and Michigan.”

Dr. Mulder testified that he also worked at the Ingram Cancer Center in Nashville, treating patients for pain management. He taught classes in several subjects at Vanderbilt University Medical Center and other colleges in the area, and he gave lectures on end-of-life care and pain management. When asked if he taught physician assistants at Vanderbilt, Dr. Mulder replied that he did so only “to the extent to which physician assistants would attend some of my lectures that were designated for the community” However, Dr. Mulder gave lectures to physician assistants at Lipscomb University and Trevecca Nazarene University, where P.A. Worthington attended, on subjects such as patient management and pain/symptom management. Dr. Mulder testified that he was familiar with the standard of care for physician assistants and for supervising physician assistants in Nashville in 2003 through his discussions with other physicians, his clinical responsibilities at the Ingram Cancer Center, and his teaching and lecturing in Nashville.

The Defendants raised an objection to Dr. Mulder testifying regarding the standard of care applicable to physician assistants and supervising physician assistants, so the trial court excused the jury. The Defendants argued that the Plaintiff failed to establish that Dr. Mulder met the requirements of the “locality rule,” *i.e.*, that Dr. Mulder was familiar with the standard of care applicable to P.A. Worthington or to Dr. Pardue’s duty to supervise P.A. Worthington in the relevant medical community or in a similar medical community during February and March 2003. In light of the Defendants’ objection, counsel for the parties were permitted to conduct “jury out” questioning of Dr. Mulder. Through questioning, the Plaintiff sought to establish first that, through his research and experience in Tennessee, Dr. Mulder had acquired personal knowledge of the standard of care in Tennessee applicable to P.A. Worthington and Dr. Pardue. In the alternative, because Dr. Mulder had personally supervised physician assistants in Muskegon, Michigan, the Plaintiff sought to establish that Dr. Mulder was familiar with the standard of care in a “similar community” to the relevant medical community. However, apparently because Muskegon is considerably smaller than Nashville, the Plaintiff argued that the relevant medical community was Hermitage, Tennessee, where Dr. Pardue’s office was located. The trial court rejected this argument, finding that Hermitage was essentially part of Nashville and that Nashville was the relevant medical community for purposes of the locality rule.

After hearing Dr. Mulder’s additional testimony, the trial court concluded that Dr. Mulder was not competent to testify as to the applicable standard of care in Nashville, because (1) his testimony did not establish that the medical community with which he was familiar in Muskegon, Michigan, was similar to the medical community in Nashville in February and March 2003, and (2) any knowledge that Dr. Mulder had regarding the standard of care in Nashville was based only on conversations he had with Nashville health care providers regarding how physician assistants were used and supervised. The trial court stated that this is “not the type of required personal/‘first hand’

knowledge” that is required to establish competency. *Allen v. Methodist Healthcare of Memphis Hospitals*, 2007 WL 969394 (Tenn. [Ct.] App. 2007) (rehearing denied); *Eckler v. Allen*, 2006 WL 3422105 (Tenn [Ct.] App. 2006) (perm. app. denied 2007).”

After the trial court’s ruling, counsel for Plaintiff insisted that he should be allowed to question Dr. Mulder regarding the standard of care applicable to Dr. Pardue, independent or separate from Dr. Pardue’s role as the supervising physician of P.A. Worthington, *i.e.*, that Dr. Pardue was negligent in that he failed to personally examine the Decedent or personally review her medical chart. The Defendants objected, arguing that the Plaintiff’s Rule 26 Notice as it related to Dr. Mulder did not disclose any anticipated testimony as to the standard of care applicable to Dr. Pardue except insofar as he allegedly failed to supervise P.A. Worthington. The trial court gave the Plaintiff until the following morning to show where in the Rule 26 Notice or otherwise he had disclosed to the Defendants that Dr. Mulder intended to express opinions regarding the independent negligence of Dr. Pardue, apart from his failure to properly supervise.

The Plaintiff did not file anything further. The next day, when trial resumed, Plaintiff’s counsel continued his direct examination of Dr. Mulder, asking, “Doctor, do you believe it’s appropriate for physicians to prescribe Demerol?” This drew an immediate objection that the question sought to elicit standard of care testimony that had been precluded by the trial court’s earlier ruling.⁹ The trial court again excused the jury and heard arguments regarding the propriety of Dr. Mulder’s testimony.¹⁰ The trial court noted that the Plaintiff had not demonstrated that he had

⁹The exchange was as follows:

[Counsel for Defendants]: . . . If [Dr. Mulder is] not permitted to testify regarding the standard of care, then for him to express opinions about what is or isn’t appropriate for someone to give, is irrelevant.

[Counsel for Plaintiff]: Your honor, I’m talking about Demerol, a prescription Demerol, is it appropriate to prescribe it.

[Counsel for Defendants]: This is his back-door effort to get around the Court’s ruling, Your Honor.

¹⁰The jury-out colloquy was:

[Counsel for Plaintiff]: But the Rule 26 statement is very clear as to both defendants are guilty of the same kinds of negligence.

Dr. Mulder’s not going to touch the standard of care on what Ms. Worthington should have done, per the Court’s order. But he will address what the deviations of the standard of care were as to Dr. Pardue from February 5th, 2003, until March, 2003

Narcotic prescriptions were not reviewed under the standard of care, which Dr. Pardue has admitted to —

[Trial Court]: Mr. Demonbreun, is that not supervisory over Worthington?

[Counsel for Plaintiff]: No, Your Honor. The physician has a direct responsibility, direct, under

disclosed to the Defendants that Dr. Mulder would testify about Dr. Pardue's negligence apart from his supervisory duties, despite having been given the opportunity to do so. The trial court found that Plaintiff's counsel continued to try to elicit standard of care testimony from Dr. Mulder, contrary to the trial court's earlier rulings. The trial court then declared a mistrial, based on behavior that the trial court described as attempts by Plaintiff's counsel "to back-door everything I've said during this case, and of [his] misstating the facts."¹¹ The trial court later entered a written order consistent with its oral ruling, citing Plaintiff's counsel's "pattern of ignoring or violating the court's rulings, particularly in the presence of the jury" by continuing to try to elicit opinion testimony on the standard of care from Dr. Mulder, contrary to the trial court's earlier ruling. Thus, the trial ended, and the jury was excused.

Post-Mistrial Proceedings

On September 25, 2007, the trial court entered an order granting the Defendants' Motion in Limine #19 to exclude the standard of care opinion of Dr. Mulder. In that order, the trial court reiterated its oral ruling that, under the locality rule, Dr. Mulder was not competent to offer opinion testimony regarding the standard of care by P.A. Worthington or for Dr. Pardue in his role as P.A. Worthington's supervising physician. It further excluded any testimony by Dr. Mulder regarding any standard of care applicable to Dr. Pardue individually because the Plaintiff "failed to provide any information, including any portion of Dr. Mulder's Rule 26 disclosure, that includes an identifiable opinion on behalf of Dr. Mulder that Dr. Pardue was negligent for anything other than alleged negligent supervision of PA Worthington." Two days later, the trial court entered an order granting four other motions *in limine* made by the Defendants, including a motion to exclude (1) comment by Plaintiff's counsel regarding alleged statutory violations by Dr. Pardue, and (2) evidence of the consent order of the Tennessee State Department of Health Board of Medical Examiners, fining Dr. Pardue and suspending his license for failing to comply with its regulations with respect to the Decedent's care.

On March 17, 2008, the Defendants filed a second motion for summary judgment, again asserting that the Plaintiff had failed to produce competent expert testimony on the issue of causation. As in their first motion for summary judgment, the Defendants argued that "[t]he Plaintiff's remaining Rule 26 witness [P.A. Donald Black] cannot raise a genuine issue of material

the standard of care, to review narcotic prescriptions.

[Trial Court]: No. The question there, is there a duty there to supervise and to review it?

[Counsel for Plaintiff]: That's not supervision of the employee, Your Honor. That is part of the physician's responsibility to review narcotic prescriptions. That is a standard of care. That has nothing to do with supervision.

¹¹ The trial court warned, "[t]he next issue is whether I find [Plaintiff's counsel] in contempt of Court." The trial court did not, however, find Plaintiff's counsel in contempt.

fact that the Defendants' alleged negligence caused Mrs. Watkins' death." P.A. Black's testimony did not establish causation, the Defendants argued, because he criticized only the number of pills P.A. Worthington prescribed to the Decedent and P.A. Worthington's failure to schedule a follow-up appointment with the Decedent within one week of her February 18, 2003 visit. P.A. Black concluded that he could not testify to a reasonable degree of medical certainty as to how many pills the Decedent took during the 30-day period preceding her death. Without expert testimony on how many pills the Decedent took, the Defendants argued, the Plaintiff could not establish that a one-week follow-up appointment with P.A. Worthington would have prevented her death. In addition, the Defendants contended, the affidavit of their expert, Dr. Farr, showed that the prescription given by P.A. Worthington was reasonable and appropriate, and that the toxicology report established that the Decedent was more than 50% at fault for her own death because she took more than the dosage prescribed. Given the Plaintiff's failure to prove the element of causation and the undisputed evidence that the Decedent was more than 50% responsible for her own death, the Defendants argued, they were entitled to summary judgment as a matter of law.

In response, the Plaintiff argued that P.A. Black was not the sole remaining witness on causation. Rather, the Plaintiff asserted, even if Drs. Mulder and Jirjis were precluded from rendering opinion testimony on the standard of care, they were nevertheless qualified to testify as to the cause of the Decedent's death. In addition, despite the trial court's earlier rulings, the Plaintiff insisted that Drs. Mulder and Jirjis were competent to testify as to the appropriate standard of care.

After hearing arguments on the Defendants' motion for summary judgment, on May 13, 2008, the trial court entered an order granting the motion. The trial court held that the expert opinions presented in P.A. Black's affidavit were not admissible because he expressed a familiarity with the standard of care in the medical community of Hermitage, Tennessee, rather than Nashville, Tennessee, and that Hermitage was not the relevant medical community for purposes of the locality rule. The trial court stated further that, even if the locality rule were satisfied as to P.A. Black's expert opinions, the Plaintiff could not establish that any alleged violation of the standard of care by the Defendants caused the Decedent's death. The trial court stated:

Specifically, the Court finds (1) the affidavit from Mr. Black does not satisfy the requirements for competency and admissibility under Tenn. Code Ann. § 29-26-115 and Tennessee case law, and (2) the Plaintiff cannot offer anything more than speculation that any alleged violation of the standard of care caused Ms. Watkins' death, and therefore the Plaintiff has failed to create a genuine issue of material fact on causation for Ms. Watkins' death.

The Court's findings of fact to support this decision include:

1. The Court previously ruled that two of the Plaintiff's disclosed Rule 26 witnesses on the standard of care (Dr. John Mulder and Dr. James Jirjis) were not competent to testify on the standard of care for a physician's assistant or the supervision of a physician's assistant. Neither physician had the personal experience or knowledge to satisfy the requirements of Tenn. Code Ann. § 29-26-115 or

Tennessee case law. The physicians were not disclosed to testify regarding any independent negligence of Dr. Pardue. The Orders were entered regarding excluding standard of care opinions from Dr. Jirjis and Dr. Mulder on September 21, 2008 and September 25, 2008, respectively.

2. The new affidavit from Donald Black, P.A., which the Plaintiff submitted in response to the Motion for Summary Judgment, does not sufficiently establish familiarity with the Nashville medical community or a similar medical community. Based upon his practice in Ft. Campbell, Kentucky, Mr. Black testified via his affidavit he is familiar with the standard of care for a physician's assistant in Hermitage, Tennessee. His affidavit does not establish familiarity with the standard of care in Nashville medical community or any similar community.

3. Even if Mr. Black was competent to testify on the standard of care, his only disclosed criticisms of the Defendants' treatment of Ms. Watkins were (a) the number of Demerol pills given, and (b) that Ms. Watkins should have been seen for an earlier follow-up appointment. The Plaintiff has offered no factual or expert testimony that can causally link these alleged violations of the standard of care to Ms. Watkins' death to create a genuine issue of material fact on causation.

4. Factually, the Plaintiff cannot offer anything more than speculation on the issue of how many Demerol pills Ms. Watkins took prior to her death. Ms. Watkins received 90 Demerol pills via a prescription from P.A. Worthington. Mr. Black testified that 40 Demerol pills would have been an appropriate prescription. The Plaintiff has offered no evidence to establish that Watkins took more than 40 Demerol pills, and any potential testimony from the Plaintiff on this issue would be impermissible speculation. [Footnote: [Dr. Deering] testified that he could only establish that Ms. Watkins took "more than one" pill, and the Plaintiff's expert testified it was "hard to tell" how many pills she took. In addition, the Plaintiff's mother disposed of the remaining pills in the prescription prior to anyone determining how many of the 90 pills were taken prior to Ms. Watkins' death.]

5. On causation, the Plaintiff also cannot establish that the number of pills prescribed or lack of an earlier follow-up appointment caused Ms. Watkins' death. The Plaintiff lacks evidence of the number of pills taken by Ms. Watkins, if any, above the 40 that were appropriate to prescribe under the applicable standard of care. Accordingly, the Plaintiff cannot offer anything more than impermissible speculation as to whether the number of pills prescribed above 40 pills caused Ms. Watkins' death. Likewise, the Plaintiff has not offered any expert testimony creating a genuine issue of material fact that an earlier follow-up appointment would have prevented Ms. Watkins' death from taking an unknown number of Demerol pills. Any causation testimony linking the two alleged violations of the standard of care to the cause of Ms. Watkins' death is purely speculative and not admissible pursuant to *Kilpatrick v. Bryant*, 868 S.W.2d 594, 602 (Tenn. 1993).

6. As a matter of law, the Plaintiff failed to create a genuine issue of material fact as to whether any violation of the standard of care more likely than not cause Ms. Watkins' death.

In sum, the trial court held that the Plaintiff did not submit sufficient evidence on the applicable standard of care to create a genuine issue of material fact, because the testimony of Drs. Mulder and Jirjis on the standard of care had been excluded, and P.A. Black was incompetent under the locality rule. Alternatively, the trial court held that, even if P.A. Black were competent to testify as to the standard of care, the only evidence of a deviation was P.A. Black's testimony that P.A. Worthington's actions in prescribing over 40 pills of Demerol to the Decedent and in failing to schedule a follow-up visit with the Decedent fell below the standard of care. Because the Plaintiff had submitted no evidence to show how many pills the Decedent actually took, no "factual or expert testimony . . . can causally link these alleged violations of the standard of care to Ms. Watkins' death to create a genuine issue of material fact on causation." From this order, the Plaintiff now appeals.

ISSUES ON APPEAL AND STANDARD OF REVIEW

The Plaintiff raises several issues on appeal:

1. Whether the trial court's granting summary judgment in favor of the Defendants was clearly erroneous or an abuse of discretion in failing to consider the competent expert affidavit of Dr. Mulder?
2. Whether the trial court's granting summary judgment *sua sponte* and without notice was clearly erroneous or an abuse of discretion in excluding P.A. Black's testimony under the locality rule?
3. Whether the trial court's granting summary judgment in favor of the Defendants was clearly erroneous or an abuse of discretion in excluding the testimony of P.A. Black under the locality rule?
4. Whether the trial court was clearly erroneous or abused its discretion in excluding the standard of care testimony of Dr. Mulder under the locality rule?
5. Whether the trial court's action was clearly erroneous or an abuse of discretion in excluding the expert witnesses Dr. Jirjis and Dr. Mulder related to the standard of care for Dr. Pardue individually because of the Plaintiff's alleged failure to disclose their opinion testimony in his Rule 26 disclosures?
6. Whether the trial court's action was clearly erroneous or an abuse of discretion in excluding from evidence adverse action taken against Dr. Pardue's license?
7. Whether the trial court's action was clearly erroneous or an abuse of discretion in denying the Plaintiff's motion to amend the complain to add a claim of negligence *per se*?

The resolution of a motion for summary judgment is a matter of law, which this Court reviews *de novo*, with no presumption of correctness afforded to the trial court's decision. ***Martin v. Norfolk S. Ry. Co.***, 271 S.W.3d 76, 84 (Tenn. 2008). Accordingly, we must review the record to determine whether the requirements of Rule 56 of the Tennessee Rules of Civil Procedure have been met. *Id.*

Summary judgment is appropriate only when the moving party can demonstrate that there are no disputed issues of material fact, and that it is entitled to a judgment as a matter of law. Tenn. R. Civ. P. 56.04; *see Byrd v. Hall*, 847 S.W.2d 208, 214 (Tenn. 1993), *cited in Hannan v. Alltel Publ'g Co.*, 270 S.W.3d 1, 3 (Tenn. 2008). The standard to be applied in assessing a motion for summary judgment is as follows:

In *Byrd*, this Court set out the basic principles involved in determining whether a motion for summary judgment should be granted. The moving party has the ultimate burden of persuading the court that “there are no disputed, material facts creating a genuine issue for trial . . . and that he is entitled to judgment as a matter of law.” *Byrd*, 847 S.W.2d at 215. If the moving party makes a properly supported motion, the burden of production then shifts to the nonmoving party to show that a genuine issue of material fact exists. *Id.*

Hannan, 270 S.W.3d at 3. The Court then explained:

[I]n Tennessee, a moving party who seeks to shift the burden of production to the nonmoving party who bears the burden of proof at trial must either: (1) affirmatively negate an essential element of the nonmoving party's claim; or (2) show that the nonmoving party cannot prove an essential element of the claim at trial.

Id. at 9. Thus, the moving party may establish that it is entitled to summary judgment by either (1) affirmatively negating an essential element of the nonmoving party's claim, or (2) showing that the nonmoving party cannot prove an essential element of the claim at trial. *Id.* at 3-5. In assessing the motion, the trial court must accept the strongest legitimate view of the evidence in favor of the nonmoving party and disregard conflicting evidence. *See Byrd*, 847 S.W.2d at 210-11. If the party seeking summary judgment makes a properly supported motion, the burden shifts to the nonmoving party to set forth specific facts that establish the existence of a genuine issue of material fact. *Martin*, 271 S.W.3d at 84; *Hannan*, 270 S.W.3d at 5. The nonmoving party may satisfy its burden of production by:

(1) pointing to evidence establishing material factual disputes that were over-looked or ignored by the moving party; (2) rehabilitating the evidence attacked by the moving party; (3) producing additional evidence establishing the existence of a genuine issue for trial; or (4) submitting an affidavit explaining the necessity for further discovery pursuant to Tenn. R. Civ. P., Rule 56.06.

McCarley v. West Quality Food Serv., 960 S.W.2d 585, 588 (Tenn. 1998).

Applying this analytical framework to this case, in order to shift the burden of production to the Plaintiff, the Defendants were required to either affirmatively negate an essential element of the Plaintiff's claim or show that he could not prove an essential element of his claim at trial. If this required showing were made, then the Plaintiff was required to produce evidence of specific facts establishing that genuine issues of material fact exist.

A trial court has broad discretion in determining the admissibility, qualifications, and competency of expert testimony. **Taylor ex rel. Gneiwek v. Jackson-Madison County Gen. Hosp. Dist.**, 231 S.W.3d 361, 365 (Tenn. Ct. App. 2006). Therefore, decisions regarding the admissibility of expert testimony will be reversed only where it can be shown that there was clear error or an abuse of discretion. **Wilson v. Patterson**, 73 S.W.3d 95, 102 (Tenn. Ct. App. 2001). Under an abuse of discretion standard, if "reasonable minds" can disagree about the propriety of the decision, it will be upheld. **Eldridge v. Eldridge**, 42 S.W.3d 82, 85 (Tenn. 2001). A trial court is deemed to have abused its discretion if it applies an incorrect legal standard, or reaches a conclusion that both is against logic and reasoning and causes an injustice to the complaining party. **Id.** (quoting **State v. Shirley**, 6 S.W.3d 243, 247 (Tenn. 1999)); see **Mercer v. Vanderbilt Univ., Inc.**, 134 S.W.3d 121, 131 (Tenn. 2004). This standard does not permit the appellate court to substitute its judgment for the trial court. **Eldridge**, 42 S.W.3d at 85.

A trial court's decision to deny a motion to amend a complaint is also reviewed under an abuse of discretion standard. **Merriman v. Smith**, 599 S.W.2d 548, 559 (Tenn. Ct. App. 1979).

ANALYSIS

Medical Malpractice Claims

Tennessee's Medical Malpractice Act, Tennessee Code Annotated § 29-26-115, *et seq.*, sets out the requirements for establishing a medical malpractice claim. Section 29-26-115 provides:

(a) In a malpractice action, the claimant shall have the burden of proving by evidence as provided by subsection (b):

(1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred;

(2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard; and

(3) As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.

(b) No person in a health care profession requiring licensure under the laws of this state shall be competent to testify in any court of law to establish the facts required to be established by subsection (a), unless the person was licensed to practice in the state or a contiguous bordering state a profession or specialty which would make the person's expert testimony relevant to the issues in the case and had practiced this profession or specialty in one (1) of these states during the year preceding the date that the alleged injury or wrongful act occurred. This rule shall apply to expert witnesses testifying for the defendant as rebuttal witnesses. The court may waive this subsection (b) when it determines that the appropriate witnesses otherwise would not be available.

Tenn. Code Ann. § 29-26-115 (Supp. 2008). Thus, under this statute, a plaintiff must prove (1) the applicable standard of care, (2) that the defendant deviated from the standard of care, and (3) that the defendant's negligent act or omission proximately caused the plaintiff's injuries, which would not have otherwise occurred but for the defendant's negligence. Where expert testimony is required, the plaintiff must provide a medical expert who meets the requirements of subsection (b) to support his claim. *See Estate of Cusatis v. Casey*, No. E2008-01786-COA-R3-CV, 2009 WL 3460451, at *4 (Tenn. Ct. App. Oct. 28, 2009).

A. Standard of Care – Competency of Dr. Mulder

The Plaintiff argues that the trial court erred in excluding Dr. Mulder as an expert on the appropriate standard of care for P.A. Worthington and Dr. Pardue. In its September 25, 2007 order, after announcing a mistrial at the September 19, 2007 trial, the trial court granted the Defendants' Motion in Limine #19 to exclude the standard of care opinion of Dr. Mulder because he did not have "the type of required personal/'first hand' knowledge that is required to establish competency," citing *Allen v. Methodist Healthcare of Memphis Hospitals*, 237 S.W.3d 293 (Tenn. Ct. App. 2007) (hereinafter "*Allen*"), and *Eckler v. Allen*, 231 S.W.3d 379 (Tenn. Ct. App. 2006) (hereinafter "*Eckler*"). In *Allen*, the court capsulized the requirements of the locality rule:

Under subsection (a)(1), known as the "locality rule," a party proffering expert testimony regarding the applicable standard of care must demonstrate that the expert has knowledge of the standard of care applicable in the defendant's community or in a community that the party demonstrates is similar to that of the defendant. *E.g.*, *Robinson v. LeCorps*, 83 S.W.3d 718, 724 (Tenn. 2002). This Court repeatedly has held that merely asserting familiarity with the local standard of care is not sufficient to demonstrate knowledge under the statutory standard. *E.g.*, *Eckler v. Allen*, 231 S.W.3d 379, 385 (Tenn. Ct. App. 2006) (perm. app. pending) (citing *Johnson v. Pratt*, No. W2003-02110-COA-R3-CV, 2005 WL 1364636, at *7 (Tenn. Ct. App.

June 9, 2005) (perm. app. denied) (citing *Mabon v. Jackson-Madison County Gen. Hosp.* 968 S.W.2d 826, 831 (Tenn. Ct. App. 1997))). Rather, the expert must present facts demonstrating how he or she has obtained knowledge of the standard of care in either the community in which the defendant practices or in a similar community. *Id.* The burden of demonstrating that the expert witness is qualified under the section is on the party proffering the witness, and is the same whether the witness is offered by the plaintiff or defendant. *Carpenter v. Klepper*, 205 S.W.3d 474, 483 (Tenn. Ct. App. 2006).

Allen, 237 S.W.3d at 295-96. *Eckler*, cited in *Allen*, addressed whether an expert's knowledge obtained by surveying physicians who practiced "in the defendant's community is sufficient under the statute, or whether the statute demands personal, firsthand knowledge." *Eckler*, 231 S.W.3d at 386. The *Eckler* Court concluded that personal, firsthand knowledge is required. It explained:

Personal is "done in person without the intervention of another." Webster's Ninth New Collegiate Dictionary, 877 (1986). Personal knowledge is "first-hand" knowledge. *See State v. Howard*, 926 S.W.2d 579, 585 (Tenn. Crim. App. 1996). Dr. Huang's familiarity with the standard of care in Memphis was garnered only through interviewing other physicians in the community; it was not based on any firsthand experience.

Id. Thus, it found that "the statute requires personal, firsthand, or direct knowledge of the applicable standard by an expert who practices in the community or in a similar community." *Id.*

In the instant case, the Plaintiff argues that Dr. Mulder's knowledge satisfied this standard. He claims that knowledge of, or familiarity with, the standard of care for physician assistants and the standard of care for physicians utilizing physician assistants does not require that the expert have actually utilized or supervised physician assistants in the same or similar community. He contends that it is sufficient for the expert have "some knowledge" of the applicable standard in order to provide relevant testimony. *See Carpenter v. Klepper*, 205 S.W.3d 474, 480 (Tenn. Ct. App. 2006). Dr. Mulder's knowledge is established here, the Plaintiff argues, because he employed physician assistants for several years in Muskegon, Michigan,¹² and because he taught physician assistants in classes and seminars in Nashville at Vanderbilt University, Lipscomb University, and Travecca Nazarene University. Dr. Mulder also considered hiring physician assistants in his Nashville practice, and consequently he reviewed applicable regulations and statutes related to the use of physician assistants.

¹²In his appellate brief, the Plaintiff states that Dr. Mulder had sufficient knowledge and familiarity with the standard of care in Nashville "and in the similar community of Muskegon, Michigan." He does not directly argue, however, that the medical communities in Muskegon and Nashville are similar. Even if this argument were properly raised, we would reject it in light of the undisputed evidence in the record that the medical community in Muskegon is much smaller than the community in Nashville.

From our careful review of the record, we find that the trial court did not abuse its discretion in excluding Dr. Mulder's testimony for purposes of establishing the standard of care for P.A. Worthington and for Dr. Pardue in supervising P.A. Worthington. The trial court gave the Plaintiff ample opportunity to establish that Dr. Mulder possessed the proper credentials to give expert opinion testimony on the standard of care. Dr. Mulder underwent two depositions as well as a thorough examination at the trial that ended in a mistrial. Considering Dr. Mulder's testimony as a whole, it showed that he believed that he was familiar with the standard of care in Nashville by virtue of his discussions with Nashville area physicians, his research, his inquiries made of Nashville physicians prior to interviewing physician assistants, and the classes and lectures he gave to physician assistants on the subject of pain management. Dr. Mulder admitted in his deposition, however, that, after moving to Tennessee, he did not work with physician assistants. Though he worked with nurse practitioners in Tennessee, he could not describe the difference between what a nurse practitioner is permitted to do versus a physician assistant, except that he thought "that training and licensure are a little bit different." Dr. Mulder could not answer questions about what tests were required for physician assistants in either Michigan or Tennessee. He had reviewed the applicable Tennessee statutes and regulations for physician assistants, but he had never see a written protocol of the type that would purportedly comply with Tennessee law. Under these circumstances, we find that the trial court did not abuse its discretion in excluding Dr. Mulder as an expert on the standard of care for a physician assistant or for a physician supervising a physician assistant. *See Eckler*, 231 S.W.3d at 387.

B. Standard of Care – Competency of P.A. Black

The Plaintiff next contends that the trial court erred in holding that P.A. Black was not qualified to give expert testimony on the applicable standard of care, because P.A. Black did not state that he was familiar with the standard of care in Nashville, Tennessee, or a community similar to Nashville. The Plaintiff argues that this was error because (1) assuming Nashville is the relevant medical community, P.A. Black's affidavit establishes the requisite familiarity with the standard of care in the Nashville medical community; (2) P.A. Black's competency was not challenged by the Defendants, and excluding his testimony without prior notice to the Plaintiff amounted to unfair surprise; and (3) Hermitage, Davidson County, Tennessee, is the relevant community because the practice of Affiliated Internists, P.C., and Dr. Pardue is situated in Hermitage.

The trial court's ruling was based solely on the language in P.A. Black's affidavit, which was submitted by the Plaintiff in response to the Defendants' post-mistrial motion for summary judgment. In April 2008, when P.A. Black signed the affidavit, he was a practicing physician assistant in Fort Campbell, Kentucky. In 2003, when the events that are the subject of the lawsuit occurred, P.A. Black was a licensed and practicing physician assistant in Tennessee.¹³ In his affidavit, P.A. Black seeks to establish his familiarity with the applicable standard of case as follows:

¹³ P.A. Black's affidavit does not state expressly where in Tennessee his practice was located in 2003.

I understand that my testimony . . . involves the recognized standard of professional practice in Hermitage, Tennessee (or similar communities, *i.e.* Clarksville, Tennessee, and Fort Campbell, Kentucky) in 2003 (and preceding year) for a physician assistant in treating, evaluating and prescribing medications for a patient like [Decedent] with (infection and pain management). . . . I am familiar with the recognized standards of professional practice for physicians and physician assistants . . . in Hermitage, Tennessee or similar communities in 2003.

...

I am familiar with the recognized standard of professional practice for physicians and physician assistants in a clinic, office practice and hospital setting as that standard existed in Hermitage, Tennessee or similar communities from 2003 to the present (“standard of care”) and specifically as that standard applied for treating patients such as [Decedent] in Hermitage, Tennessee or similar communities in 2003. In addition, I am familiar with communities such as Nashville and Hermitage, Tennessee and similar communities in Tennessee and Kentucky, including Clarksville, Tennessee and Fort Campbell, Kentucky. I am familiar with the populations of Nashville, Hermitage, Clarksville, Fort Campbell and the number and types of hospitals and medical schools in these communities as well as the number and nature of physician assistant[s] in these communities. I consider the standards of professional practice for a physician assistant such as P.A. Worthington . . . in 2003 to be similar to the recognized standards of professional practice for a physician assistant that would have been applied to treatment of such a patient in Clarksville, Tennessee and Fort Campbell, Kentucky. I consider the standards of professional practice for a physician such as Dr. Travis K. Pardue . . . in 2003 (where a physician assistant is utilized) to be similar to the recognized standards of professional practice for a physician that would have been applied to treatment of such a patient in Clarksville, Tennessee and Fort Campbell, Kentucky. Based upon my knowledge and experience, I am familiar with the recognized standard of acceptable professional practice for physician assistants and physicians using physician assistants . . . in Hermitage, Tennessee and similar communities I also consider Clarksville, Tennessee and Fort Campbell [,] Kentucky [to] be “similar communities” for purposes of comparing the applicable standard of care for physician assistants in 2003.

Parsing through the blizzard of words in the affidavit, it is clear that, although P.A. Black mentions Nashville, he claims only to be familiar with the Nashville “community” and with the number of hospitals, medical schools, and physician assistants in Nashville. Nowhere does he state that he is (a) familiar with the standard of care in Nashville, or (b) familiar with the standard of care in a community that is similar to Nashville. Rather, his affidavit is premised on Hermitage as the relevant medical community.

The Plaintiff claims that the trial court’s *sua sponte* ruling that P.A. Black was not competent constituted “unfair surprise.” However, the issue of the relevant medical community arose in the trial (which ended in mistrial) during Dr. Mulder’s testimony. Dr. Mulder had not worked with

physician assistants in Tennessee, but had done so in Muskegon, Michigan, a community that is admittedly much smaller than the Nashville community. After the trial court ruled that Dr. Mulder was not competent to opine on the standard of care based on his experience in Tennessee, the Plaintiff sought to establish that Dr. Mulder was familiar with the standard of care in Hermitage, Tennessee, which is similar in size to Muskegon. Although the trial court ultimately excluded Dr. Mulder's testimony on the standard of care because it was not based on "first-hand" knowledge, it also ruled in open court that Nashville, not Hermitage, was the relevant medical community.

This ruling occurred in September 2007. The affidavit from P.A. Black was filed by the Plaintiff in April 2008, about seven months later. Thus, the Plaintiff cannot claim "unfair surprise" at the trial court's ruling as to P.A. Black's competence, especially in light of the fact that a similar issue recently had been raised and adjudicated with respect to Dr. Mulder.

Even if the trial court's decision was not procedurally flawed, the Plaintiff argues strenuously that the relevant medical "community" under Tennessee Code Annotated § 29-26-115(a) is Hermitage, Tennessee, not Nashville, Tennessee. The Plaintiff contends that Hermitage is a distinct community in Davidson County and notes that it has been described by this Court as "a bedroom community outside of Nashville." *See Fisher v. Green*, No. 01A01-9708-CH-00389, 1999 WL 5081, at *1 (Tenn. Ct. App. Jan. 7, 1999). Contrary to the trial court's ruling, the Plaintiff argues, Hermitage is not a "neighborhood" in Nashville. The Plaintiff points to internet websites stating that Hermitage is one of three distinct communities that exist in the relevant part of Davidson County, along with Donelson and Old Hickory. He claims that the history of the hospital in Hermitage, the Summit Medical Center, as described on its website, was created to give local residents an alternative to traveling to downtown Nashville hospitals. This, he argues, is proof that Hermitage is a distinct medical community for purposes of the locality rule.

Section 29-26-115(a) states that a plaintiff must prove "the recognized standard of acceptable professional practice . . . in the community in which the defendant practices or in a similar community. . . ." Tenn. Code Ann. § 29-26-115(a)(1) (Supp. 2008). The term "community" is not defined in the statute. This Court has stated that "the only relevant 'community' is the community in which the defendant physician actually practices or in a similar community." *Kenyon v. Handal*, 122 S.W.3d 743, (Tenn. Ct. App. 2003). Here, Dr. Pardue's office is located in Hermitage, Tennessee. The trial court held that the relevant medical community was the greater metropolitan area of Nashville, which includes Hermitage. We cannot hold that the trial court erred in so ruling.

Consequently, the Plaintiff was obliged to present testimony from an expert who was familiar with the standard of care in the Nashville metropolitan area or a community that was similar to the Nashville metropolitan area. P.A. Black's affidavit does not establish such familiarity. Under these circumstances, we cannot conclude that the trial court erred in holding P.A. Black's testimony inadmissible on the standard of care. *Taylor ex rel. Gneiweck v. Jackson-Madison County Gen. Hosp. Dist.*, 231 S.W.3d 361, 365 (Tenn. Ct. App. 2006) (trial court has broad discretion in determining admissibility of expert testimony).

***C. Adequacy of Rule 26 Notice – Testimony of Dr. Mulder and Dr. Jirjis
on Dr. Pardue’s Independent Negligence***

After the mistrial, in its September 25, 2007 order, the trial court held that Dr. Mulder could not testify regarding any standard of care applicable to Dr. Pardue independent of his supervisory role, because the Plaintiff “failed to provide any information, including any portion of Dr. Mulder’s Rule 26 disclosure, that includes an identifiable opinion by Dr. Mulder that Dr. Pardue was negligent for anything other than alleged negligent supervision of PA Worthington.” On appeal, the Plaintiff argues that the trial court erred in excluding the testimony of Drs. Mulder and Jirjis on the independent negligence of Dr. Pardue, because the Rule 26 disclosures sufficiently put the Defendants on notice that these experts intended to testify against both Dr. Pardue and his professional corporation. In support, the Plaintiff cites the following portions of the final Rule 26 Notice:

3. Dr. James N. Jirjis, M.D.; Vanderbilt University Medical Center

4. Dr. John A. Mulder, M.D.; Vanderbilt University Medical Center

Drs. James N. Jirjis, M.D. and John A. Mulder, M.D. are . . . expected to testify and render expert opinions, based on their respective training and experience, and within a reasonable degree of medical certainty, as follows:

...

f) . . . The writing of this exceptionally large Demerol prescription itself under these circumstances was substandard, and if the required “active and continuous” oversight by the physician had been present through a “written protocol” or his actual physical presence in the medical office, availability by phone or chart review within a reasonable period of time, it would not have been permitted and Mrs. Watkins would not have died as a result.

...

h) There is no evidence of “active and continuous” supervision as required by State law of Ms. Worthington as a physician’s assistant by her employer Dr. Travis K. Pardue, M.D. in prescribing sedating medications such as Demerol, in that no “written protocol” existed whatsoever and no chart review occurred as is required; hence no guidance or oversight existed in assisting her in the choice of prescribing Demerol for Ms. Watkins, who had a documented history of seizures, and also simultaneously in writing a prescription for Stadol. This resulted in substandard management and care being provided to the patient.

i) That early in the evening on March 5, 2003, Ms. Watkins died from a massive mal seizure following acute combined drug intoxication of meperidine, promethazine and diphenhydramine, and had never at any time been warned by Ms. Worthington, Dr. Pardue or any of his other employees at any time that seizure and death could result from taking Demerol as it had been prescribed to her. Had she been properly warned,

as the standard of care required, Ms. Watkins would not have died as appropriate medical care would have been provided in time to save her life.

...

k) That the personnel of Affiliated Internists, P.C. including doctors, nurses and physicians' assistants, and Travis K. Pardue failed to comply with the applicable standard of acceptable profession medical practice in the care and treatment of Ms. Watkins. Ms. Watkins death occurred as a result of the negligence of Affiliated Internists, P.C. employees and Travis K. Pardue, M.D., in prescribing excessively large quantities of Demerol with absolutely no warning as to its toxic side effects which, after being taken twelve days as prescribed, resulted in "acute combined drug intoxication," mal seizure, and death. The said defendants were also negligent and their care substandard for their failure to manage and follow Ms. Watkins' care and treatment, to clearly warn her of the likelihood of seizure in taking Demerol for an extended time period, and, finally, in failing to again warn her and order her to **immediately** proceed to the emergency room for fluids on the morning of her death when she called to report her symptoms. Had a "written protocol" existed as required by law it would have directly affected this aspect of the patient's management and care, and resulted in appropriate action being taken by Ms. Watkins before her death.

l) Drs. Jirjis and Mulder are expected to testify and render opinions about the care and treatment provided Ms. Watkins by the defendants, about the appropriate standard of care required for such care and treatment, and what care should have been provided Ms. Watkins in order to satisfy the standard of care. They will also render opinions about the cause of death and whether the absence of a "written protocol," which should have been in place as required under State law, directly contributed to the patient's death.

The Defendants argue that the above-quoted Rule 26 Notice is "nothing short of reiterations of this allegation of negligent supervision or general statements of negligence, which when taken in context, are merely references to the repeated claim of 'negligent supervision.' "

Rule 26 provides in pertinent part:

4) Trial Preparation: Experts. Discovery of facts known and opinions held by experts, otherwise discoverable under the provisions of subdivision (1) of this rule and acquired or developed in anticipation of litigation or for trial, may be obtained only as follows:

(A)(1) A party may through interrogatories require any other party to identify each person whom the other party expects to call as an expert witness at trial, to state the subject matter on which the expert is expected to testify, and to state the substance

of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion.

Tenn. R. Civ. P. 26.02(4). Where a party asserts that an opposing party's Rule 26 expert's disclosures did not disclose an opinion (or that there was not a proper supplementation of opinion pursuant to Rule 26.05), a court may exclude the expert's testimony pursuant to Rule 37.03 of the Tennessee Rules of Civil Procedure.¹⁴ Exclusion is proper only if the disclosures failed to give the opposing side reasonable notice of the opinions such that, without exclusion, there would be unfair surprise or trial by ambush. *Robinson v. Baptist Mem. Hosp.-Lauderdale*, No. W2006-01404-COA-R3-CV, 2007 WL 2318185, at *4 (Tenn. Ct. App. Aug. 15, 2007). The trial court has broad discretion over whether to exclude testimony pursuant to Rule 37.03, and decisions on such matters are, therefore, reviewed for an abuse of that discretion. *Id.*

In light of the Rule 26 disclosures, there was much discussion with the trial judge on whether the Plaintiff's claims against Dr. Pardue were based on negligent supervision or on his direct negligence, independent of his duty to supervise P.A. Worthington. The Plaintiff insisted that, in addition to claims of negligent supervision, his complaint was also based on independent duties of Dr. Pardue, aside from his supervisory duties, that could sustain his claim of medical malpractice.

We note that the trial court had previously denied the Plaintiff's motion to amend the complaint to add negligence *per se* claims based on Dr. Pardue's violation of the regulations requiring written protocols and review of the patient's data and chart; the denial of that motion to amend is addressed below. However, as to the claims that were before the trial court at the time it issued its September 25, 2007 order, we agree with the trial court that those claims pertained only to Dr. Pardue's role as a supervising physician. Therefore, we find no error in the trial court's decision to reject Dr. Mulder's standard of care testimony as it related to Dr. Pardue's breach of an independent duty.

Negligence Per Se

A. Overview

Next, we consider the trial court's denial of the Plaintiff's motion to amend the complaint to assert a negligence claim and a negligence *per se* claim based on Dr. Pardue's violations of

¹⁴Rule 37.03 provides:

A party who without substantial justification fails to supplement or amend responses to discovery requests as required by Rule 26.05 is not permitted, unless such failure is harmless, to use as evidence at trial, at a hearing, or on a motion any witness or information not so disclosed. In addition to or in lieu of this sanction, the court on motion may impose other appropriate sanctions. In addition to requiring payment of reasonable expenses (including attorney fees) caused by the failure, these sanctions may include any of the actions authorized under Rule 37.02(A), (B), and (C) and may include informing the jury of the failure to supplement or amend.

Tennessee regulations applicable to physicians who supervise physician assistants. The regulations are promulgated jointly by the Tennessee Board of Medical Examiners pursuant to Tennessee Code Annotated § 63-6-101, and by the Committee on Physician Assistants pursuant to the Physician Assistants Act, Tennessee Code Annotated § 63-19-101, *et seq.* The regulation at issue states:

The following requirements apply to a supervising physician who supervises one or more physician assistants:

...

(5) Protocols are required and:

- (a) shall be jointly developed and approved by the supervising physician and physician assistant;
- (b) shall outline and cover the applicable standard of care;
- (c) shall be reviewed and updated biennially;
- (d) shall be maintained at the practice site;
- (e) shall account for all protocol drugs by appropriate formulary;
- (f) shall be specific to the population seen;
- (g) shall be dated and signed; and
- (h) shall be made available upon request for inspection by the board or the committee.

(6) The supervising physician shall be responsible for ensuring compliance with the applicable standard of care under (5). . . .

(7) Within ten (10) business days after the physician assistant has examined a patient who falls in one of the following categories, the supervising physician shall make a personal review of the historical, physical, and therapeutic data gathered by the physician assistant on that patient and shall so certify in the patient's chart within thirty (30) days:

- (a) when medically indicated;
- (b) when requested by the patient;
- (c) when prescriptions written by the physician assistant fall outside the protocols;
- (d) when prescriptions are written by a physician assistant who possesses a temporary license; and
- (e) when a controlled drug has been prescribed.

(8) In any event, a supervising physician shall personally review at least twenty percent (20%) of charts monitored or written by the physician assistant every thirty (30) days.

TENN. COMP. R. & REGS. 0880-2-.18(5)-(8) (2007). The trial court denied the Plaintiff's motion to amend, finding that the regulation did not "establish a standard of care" and consequently that

allowing the amendment would be “futile.” We must determine, then, whether the regulation at issue constitutes a standard of care applicable to Dr. Pardue in this case.

The RESTATEMENT (THIRD) OF TORTS § 14 on negligence *per se*, states: “An actor is negligent if, without excuse, the actor violates a statute that is designed to protect against the type of accident the actor’s conduct causes, and if the accident victim is within the class of persons the statute is designed to protect.” RESTATEMENT (THIRD) OF TORTS § 14 (2005). This Court has explained:

To prevail on a negligence *per se* theory, the plaintiff may, in certain circumstances . . . rely on a statute or regulation as proof of the applicable standard of care. Proof of “[a]n unexplained violation of that standard renders the defendant negligent as a matter of law,” so long as the violation was the proximate cause of the injuries and the alleged injuries were of the type which the statute was designed to prevent.

King v. Danek Med., Inc., 37 S.W.3d 429, 459 (Tenn. Ct. App. 2000) (quoting ***McNeil Pharm. v. Hawkins***, 686 A.2d 567, 578 (D.C. 1996)).

The RESTATEMENT (THIRD) OF TORTS § 38, states: “When a statute requires an actor to act for the protection of another, the court may rely on the statute to decide that an affirmative duty exists and its scope.” RESTATEMENT (THIRD) OF TORTS § 38 (2005); *see Alex v. Armstrong*, 385 S.W.2d 110, 114 (Tenn. 1964) (“In order to found an action on the violation of a statute . . . the person suing must be such a person as is within the protection of the law and intended to be benefitted thereby. . . .”) (quoting ***Carter v. Redmond***, 218 S.W. 217, 218 (1920)). *See also Uithoven ex rel. Cook v. Spinnaker’s of Rivergate, Inc.*, 878 S.W.2d 934, 937 (Tenn. 1994) (In order to establish negligence *per se*, it must be shown that the Statute violated was designed to impose a duty or prohibit an act for the benefit of a person or the public.”). The comments to Section 38 of the Restatement explain:

Whether a statute provides an affirmative duty in tort is different from negligence *per se* for statutory violations. Negligence *per se* relies on a specific statutory standard to premit reference to the more general reasonable-care standard. . . . Employing a statute to provide a tort duty where none previously existed creates a new basis for liability not previously recognized by tort law.

RESTATEMENT (THIRD) OF TORTS § 38 cmt. d.

B. Caselaw

On appeal, the Defendants assert that the regulations at issue “involve administrative requirements, as the Trial Court held.” In support, they cite ***King***, which involved allegations of negligence *per se* against the manufacturer of pedicle screw devices based on its conduct in marketing the device for a use that had not been approved by the FDA in violation of FDA regulatory

restraints. **King**, 37 S.W.3d at 455-56. The Court in **King** discussed the type of statute or regulation that can form the basis for a claim of negligence *per se*:

When alleging a statute or regulation based negligence *per se* claim, it is not sufficient for a plaintiff to assume . . . that the alleged violation of a statute automatically supports a claim of negligence *per se*. Even if the plaintiffs are within the class to be protected by the statute, . . . a statutory negligence *per se* claim cannot stand unless the statute establishes a standard of care.

Id. at 460. The **King** court quoted a federal decision discussing when a regulation is not a standard of care, but merely an administrative requirement:

When a statutory provision does not define a standard of care but merely imposes an administrative requirement, such as the requirement to obtain a license or to file a report to support a regulatory scheme, violation of such requirement will not support a negligence *per se* claim. Even if the regulatory scheme as a whole is designed to protect the public or to promote safety, the licensing duty itself is not a standard of care, but an administrative requirement.

...

[R]ules [that] are administrative . . . do not amount to a legislative judgment as to the standard of care, and accordingly, breach of these provisions in themselves cannot underlie a negligence *per se* claim.

Id. at 460 (quoting **Talley v. Danek Med., Inc.**, 179 F.3d 154, 159 (4th Cir.1999)). In **King**, the court found that the requirement that a device be “approved by the FDA before being marketed – as opposed to a specific substantive requirement that a device be safe and effective – is only a tool to facilitate administration of the underlying regulatory scheme.” **Id.** at 457 (quoting **Talley**, 179 F.3d at 161). Finding that the regulatory requirement “lacks any independent substantive content,” the court held that “it does not impose a standard of care.” **Id.** The court analogized the regulatory infraction to the failure to have a driver’s license. **Id.** It observed that Tennessee cases involving a statutory or regulatory basis for a negligence *per se* claim “apply statutes with substantive context, rather than . . . only administrative requirements.” **Id.** at 458 (citing **Cook v. Spinnaker’s of Rivergate, Inc.**, 878 S.W.2d 934, 937 (Tenn. 1994)). Because the **King** Court found the regulation at issue to be only an administrative requirement, it did not address the issue of whether the plaintiff was within the protection of the statute or intended to be benefitted by it. Thus, the dismissal of the plaintiff’s negligence claim was affirmed.

In contrast, this court found that violation of a statute by a physician could form the basis of a negligence *per se* claim if the statute sets out a standard of care in **Vickroy v. Pathways, Inc.**, 2004 WL 3048972 (Tenn. Ct. App. Dec. 30, 2004). In **Vickroy**, the statute at issue required a medical professional who involuntarily commits a patient to a mental institution to have first personally examined the patient before signing the certificate of need. The defendant physician signed the certificate of need to commit the plaintiff, relying on a physical examination performed earlier by

another physician who had since gone off duty. *Id.* at *1-2. The plaintiff's claims included a claim of negligence *per se* based on the physician's failure to personally examine her before signing the certificate. The court rejected the plaintiff's claim of medical malpractice on the basis that the plaintiff had not produced expert testimony on the issue of causation. *Id.* at *8. The *Vickroy* court found, however, that apart from medical malpractice, the statute established the standard of conduct for a claim of negligence *per se* based on a violation of Tenn. Code Ann. § 33-6-404.¹⁵ The defendant in *Vickroy* did not expressly argue that the statute was merely an "administrative" requirement. Similar to that, he contended that it did not create a duty on his part to *personally* examine the plaintiff, only to make certain that *a* medical professional had examined her before he signed the certificate of need for her commitment. *Id.* at *6. This argument was rejected. The *Vickroy* Court looked at other statutes on commitment, as well as the statute at issue, and concluded that the "legislative expectation was that the involuntary commitment of a patient must be done by a professional who has examined the patient, and not based on the statements and observations of others." *Id.* Thus, the Court found that the legislature had, by enacting the statute, established this as a standard of conduct for a medical professional in involuntary commitments.

The Plaintiff cites two Georgia cases in support of the argument that the trial court erred in denying the motion to amend, *Central Anesthesia Assocs., P.C. v. Worthy*, 333 S.E.2d 829 (Ga. 1985) and *Rockefeller v. Kaiser Found. Health Plan of Ga.*, 554 S.E.2d 623 (Ga. Ct. App. 2001). The Defendants rightly point out that cases such as these from other jurisdictions are not binding on this Court. We agree with this observation, but nevertheless find them instructive.

In *Central Anesthesia*, the plaintiff underwent surgery performed by the defendant physician. *Central Anesthesia*, 333 S.E.2d at 830. The anesthesia for the surgery was administered by a nurse who was a student nurse anesthetist. The anesthesia was improperly administered, and the plaintiff ended up in a coma with brain damage. *Id.* The plaintiff sued, alleging, *inter alia*, that the defendants were negligent *per se* in permitting the anesthesia to be administered by the student nurse anesthetist without proper supervision. The plaintiff relied on a Georgia statute that allowed anesthesia to be administered "by a certified registered nurse anesthetist, provided that such anesthesia is administered under the direction and responsibility of a duly licensed physician with training or experience in anesthesia." *Id.* at 831-32 (quoting O.C.G.A. § 43-26-9(b)).

On appeal, the defendants argued that the statute on which the plaintiff relied "is a licensing statute which does not establish a standard of conduct constituting ordinary care," and thus its violation could not constitute negligence *per se*. *Id.* at 832. The *Central Anesthesia* court disagreed, holding that, although the statute "does not establish a standard of conduct as to what anesthesia plan shall be used under which conditions, it nevertheless establishes a standard of conduct constituting ordinary care, and hence it is unlike [a] licensing requirement. . . ." *Id.* at 833.

¹⁵ In *Vickroy*, some of the plaintiff's claims were deemed to be not medical malpractice because the certificate of need to commit a patient could be signed by a "designated professional" who was not a physician, and the plaintiff claimed damages not arising out of the defendant physician's medical judgment. *Vickroy*, 2004 WL 3048972, at *10-11. In *dicta*, however, the *Vickroy* court observed that it was unlikely that the standard of care would permit a physician to commit a patient without a personal examination, in light of the statute. *Id.*, at *8 n.10.

The Court emphasized that the defendants' undisputed violation of the statute "supplies only the duty and breach of duty elements of a tort, and the plaintiffs must still prove a causal connection (proximate cause) between the breach of this statutory duty and the injuries sustained by [the plaintiff], as well as their damages." *Id.* at 831.

Relying on *Central Anesthesia*, the Georgia Court of Appeals in *Rockefeller v. Kaiser Foundation* found that the violation of a statute governing the supervision of physician assistants could be the basis for a claim of negligence *per se*. In *Rockefeller*, the plaintiff was examined by a physician assistant, complaining of a cough and fever. The physician assistant diagnosed a virus and prescribed symptomatic medication. The prescription was co-signed by a physician. *Rockefeller*, 554 S.E.2d at 625. The next day the plaintiff was hospitalized with pneumonia, and ended up with permanent disabilities. *Id.* The plaintiff sued, alleging violations of Georgia statutes. Specifically, the plaintiff alleged that the Board of Medical Examiners had not authorized the physician assistant to treat and diagnose patients, and that the physician assistant was not supervised by a physician who had been approved by the Board for such supervision. *Id.* The Court found that the statute

... establishes a standard of conduct under which a [physician assistant] may perform only those tasks in his job description and only under the direction of the applying physician. These limitations are intended to protect the health and welfare of patients such as [the plaintiff], by insuring that the [physician assistant's] treatment of the patient is overseen by a physician who is qualified to supervise the [physician assistant] in the tasks performed. These limitations are certainly intended to guard against harm suffered by patients as a result of mistakes such as those charged to [the physician assistant]. Consequently, under the analysis set forth in *Worthy*, the defendants' violation of this statutory standard constitutes negligence *per se*.

Id. at 627 (footnote omitted). The *Rockefeller* Court noted that the plaintiff still had to establish that the defendants' violation of the statute caused her injuries. *Id.* at 628 n.17. It explained:

In essence, [the plaintiff] must show that if [the physician assistant] had been supervised by a Board-approved physician, he would have accurately diagnosed her condition and ordered the correct medications. Basically, this will require her to prove that [the physician assistant] was negligently supervised. In practice, therefore, [the plaintiff's] negligence *per se* theory does not materially advance her cause.

Id. Thus, the *Rockefeller* Court found that the plaintiff could assert a claim of negligence *per se* based on the statutory violations, but that she still had the obligation to prove proximate cause. *Id.* at 628.

C. Statutes and Regulations

With this caselaw in mind, then, we examine the regulations at issue to determine whether they set out a standard of care, as opposed to a mere administrative requirement, and to determine whether the Decedent falls within the protection of the regulations and was intended to be benefitted by them. *See King*, 37 S.W.3d at 460; *Alex*, 385 S.W.2d at 114.

The regulations on which the Plaintiff relies were promulgated pursuant to the Tennessee Physician Assistants Act, codified at Tennessee Code Annotated § 63-19-101, *et seq.* Because the regulations pertain to the supervision of physician assistants by physicians, they were jointly adopted by the Committee on Physician Assistants and the Board of Medical Examiners. *See* Tenn. Code Ann. § 63-19-106(c) (2004).

The Physician Assistants Act permits a licensed physician assistant to perform medical services that constitute the practice of medicine, services which, but for the Act's provisions, could be performed only by a licensed physician. Tenn. Code Ann. § 63-19-102(5) (2004). The Act mandates that a physician assistant may render these services “only under the supervision of a licensed physician.” Tenn. Code Ann. § 63-19-106(a). While the supervising physician need not be constantly present, the Act states expressly that “[s]upervision requires active and continuous overview of the physician assistant’s activities to ensure that the physician’s directions and advice are in fact implemented” Section 63-19-106(a)(1).

In the Act, the legislature directs the Committee on Physician Assistants and the Board of Medical Examiners to “adopt . . . regulations governing the supervising physician’s personal review of historical, physical and therapeutic data contained in the charts of patients examined by the physician assistant.” *Id.* The Act also mandates the adoption of a written protocol, developed jointly by the supervising physician and the physician assistant. Section 63-19-106(a)(2). The protocol is to set forth “the range of services that may be provided,” and must include “a discussion of the problems and conditions likely to be encountered by the physician assistant and the appropriate treatment for these problems and conditions.” *Id.* The Act requires that the written protocol be maintained and available to, *inter alia*, the Board of Medical Examiners. *Id.*

The regulations on which the Plaintiff in this case seeks to rely mirror almost exactly the language of the Physician Assistants Act, adding specific requirements. The written protocol, for example, must be “dated and signed” and “reviewed and updated biennially.” TENN. COMP. R. & REGS. 0880-2-.18(5)(c) and (g). The physician’s mandated review of patients’ “historical, physical and therapeutic data” must take place “[w]ithin ten (10) days” after the physician assistant examines

the patient, and must take place, *inter alia*, “when a controlled drug has been prescribed.”¹⁶ *Id.* at 0880-2-.18(7)(e).

The Act emphasizes repeatedly the supervising physician’s duty to supervise the physician assistant. It states that the physician assistant functions “only under the control and responsibility” of the supervising physician. Tenn. Code Ann. § 63-19-106(b). It directs that “[t]here shall, at all times, be a physician who is answerable for the actions of the physician assistant.” *Id.* The Act states explicitly that the supervising physician “has the duty of assuring that there is proper supervision and control of the physician assistant” and that the physician assistant’s actions are “appropriate.” *Id.*

1. Written Protocols

We consider first the regulation requiring written protocols. Clearly the legislature sought to require physicians to communicate with the physician assistants under their supervision, and to provide “active and continuous overview.” The statute and regulation convey the “legislative expectation” that the communication would include the information that would be contained in a protocol, namely, the standard of care, the “problems and conditions likely to be encountered by the physician assistant,” and the “appropriate treatment.” *See Vickroy*, 2004 WL 3048972, at *6; Tenn. Code Ann. § 63-19-106(a)(2). Certainly, the development and implementation of the written protocol is a required part of the physician’s supervision. However, after reviewing the regulation, we must agree with the trial court that the purpose of this regulation requiring a written protocol appears to be primarily administrative, to help the Board confirm that the appropriate communications are taking place between the physician and the physician assistant. The regulation indicates that the protocol is required only to “outline” the standard of care for the physician assistant and the supervising physician. It specifies that the written protocol must be signed and dated, maintained at the physician’s practice location, reviewed and updated every two years, and be made available to the Board upon request. Overall, the requirement appears to be less substantive than “a tool to facilitate administration of the underlying regulatory scheme.” *King*, 37 S.W.3d at 457 (quoting *Talley*, 179 F.3d at 161). Thus, we agree with the trial court’s holding that violation of this regulation will not, in and of itself, support a claim of negligence or negligence *per se*.

2. Personal Review of Chart

We next consider the regulation imposing an obligation on the supervising physician to “make a personal review” of the patient data within ten days after the examination of a patient for whom a controlled drug is prescribed. *See* TENN. COMP. R. & REGS. 0880-2-.18(7). The Physician Assistants Act imposes the “personal review” requirement on the supervising physician in the same

¹⁶ The Physician Assistants’ Act also includes numerous restrictions on a physician assistant’s prescription of controlled substances. *See* Tenn. Code Ann. § 63-19-107(2). The Act authorizes the Committee on Physician Assistants and the Board of Medical Examiners to “adopt additional rules governing the prescribing of controlled substances by physician assistants.” *Id.* at § 63-19-107(2)(A).

subsection that mandates “active and continuous overview of the physician assistant’s activities.” Tenn. Code Ann. § 63-19-106(a)(1). Clearly this was not intended to be a perfunctory review. From the language used in the statute and the regulation, it is apparent that the legislature intended to mandate that the supervising physician’s “active” oversight include the exercise of the physician’s independent judgment as to whether the physician assistant’s actions were appropriate. The Board added the regulatory requirement that the “personal review” take place within ten business days. This indicates that the Board intended for the supervising physician’s review to be substantive and sufficiently contemporaneous with the actions of the physician assistant so as to enable the physician to take corrective action if, in the exercise of his independent judgment, the physician assistant’s actions were not appropriate.¹⁷ Overall, the statute and the regulation, taken together, appear to be substantive, “a legislative judgment as to the standard of care,” establishing a floor below which the standard of care for a supervising physician may not fall. **King**, 37 S.W.3d at 460 (quoting **Talley**, 179 F.3d at 159).

Moreover, the injury to the Decedent in this case appears to be “of the type which the statute [and regulation] was designed to prevent.” **King**, 37 S.W.3d at 459 (quoting **McNeil**, 686 A.2d at 578). The Plaintiff claims that Dr. Pardue was aware that the Decedent had a history of seizures and was suspected of substance abuse. The Plaintiff asserts that such a large prescription of medications that lower the threshold for seizures, with no intervening follow-up visit, was inappropriate, and that this would have been evident to Dr. Pardue had he reviewed the Decedent’s data and chart within ten business days, as required. Indeed, the discipline imposed on Dr. Pardue by the Board of Medical Examiners was specifically for failing to review *this Decedent’s* data and chart within ten business days after P.A. Worthington’s examination.¹⁸ The requirements in the statute and regulation clearly appear to be “intended to guard against harm suffered by patients as a result of mistakes such as those charged” to Dr. Pardue. **Rockefeller**, 554 S.E.2d at 627.

Thus, we must respectfully disagree with the trial court’s finding that TENN. COMP. R. & REGS. 0880-2-.18(7) cannot support the Plaintiff’s claim of negligence *per se*. We find that it constitutes a standard of care, and that the trial court erred in denying the Plaintiff’s motion to amend the complaint to allege a claim of negligence or negligence *per se* based on the breach of that standard.

As we have indicated, the Plaintiff must still prove that Dr. Pardue’s violation of the regulation was the proximate cause of the Decedent’s death. **See King**, 37 S.W.3d at 459 (quoting **McNeil**, 686 A.2d at 578). This requires proof that, had Dr. Pardue timely conducted an independent

¹⁷The regulatory duty to review arises out of a regulation applicable to physicians who supervise physician assistants. **See** TENN. R. & REGS. 0880-2-.18(7) (2007). As in **Vickroy**, the regulation creates a direct duty to the patient to review the patient’s data and chart and make an independent judgment as to the appropriate treatment. **See Vickroy**, 2004 WL 3048972, at *6-8.

¹⁸The Decedent was examined by P.A. Worthington on February 18, 2003, and given the prescriptions at issue. The Decedent telephoned P.A. Worthington, complaining of nausea and vomiting, on the eleventh business day after her examination, and died later that day.

personal review of the Decedent's data and chart, actions would have been taken that would have prevented the Decedent's death. As the negligence *per se* claim was not before the trial court when it ruled on the Plaintiff's proffered causation testimony, and the standard of care testimony on all of the remaining claims has been excluded, we find that it would be inappropriate at this juncture for us to review the trial court's causation rulings. We hold only that, on remand, the Plaintiff may amend his complaint to assert a claim of negligence *per se* based on the violation of TENN. COMP. R. & REGS. 0880-2-.18(7), and that he may have the opportunity to establish the elements of this claim.

D. Exclusion of Evidence of Adverse Action Against Dr. Pardue

The trial court granted the Defendants' motion to exclude from evidence comments about alleged regulatory violations and the consent order of the Board of Medical Examiners, which fined Dr. Pardue and placed his medical license on probation for five years. On appeal, the Plaintiff argues that, if the grant of summary judgment in favor of the Defendants is reversed, we should reverse this ruling as well and find that, if Dr. Pardue testifies on his own behalf, evidence of his licensure status would be admissible for impeachment purposes, citing *Sneed v. Stovall*, 156 S.W.3d 1 (Tenn. Ct. App. 2004), and *Sneed v. Stovall*, 22 S.W.3d 277 (Tenn. Ct. App. 1999) (same case); *see also Linton v. Davis*, 887 N.E.2d 960 (Ind. App. 2008); *Hostel v. Schwartz*, 756 N.W.2d 363 (S. Dakota 2008). On remand, the trial court's ruling on this motion in limine may be revisited in light of our holding herein on the claim of negligence *per se*. We express no opinion on the resolution of this motion on remand.

CONCLUSION

In sum, we affirm the trial court's decision to exclude the testimony of Dr. Mulder on the standard of care for a physician assistant or a physician supervising a physician assistant; we also affirm the trial court's exclusion of P.A. Black's testimony on the standard of care based on the locality rule. We affirm the trial court's decision to disallow the standard of care testimony of Drs. Mulder and Jirjis on the independent duty of Dr. Pardue, based on the Rule 26 disclosure. Furthermore, we conclude that TENN. COMP. R. & REGS. 0880-2-.18(7) sets out a standard of care and, thus, reverse the trial court's denial of the Plaintiff's motion to amend the complaint to add a claim of negligence *per se* based on the alleged violation of that regulation. We affirm as to the remainder of the denial of the motion to amend the complaint. We affirm the trial court's grant of summary judgment in favor of the Defendants on all claims except the claim of negligence *per se* arising out of Dr. Pardue's violation of TENN. COMP. R & REGS. 0880-2-.18(7). All other issues raised on appeal are pretermitted by these holdings.

The decision of the trial court is affirmed in part and reversed in part, and the cause is remanded to the trial court for further proceedings consistent with this Opinion. Costs on appeal are assessed one-half to Appellant John Mark Watkins, and his surety, and one-half to Appellees Affiliated Internists, P.C. and Travis K. Pardue, M.D., for which execution may issue if necessary.

HOLLY M. KIRBY, JUDGE